HIPAA (Health Insurance Portability and Accountability Act) Project

Frequently Asked Questions and Answers (Updated 07/2004)

DUAL SUPPORT

1) How long will the dual support be available?

The Medical Assistance Administration is actively moving forward to end dual support. We are working with targeted provider groups at this time to assist them with their transition to HIPAA compliant claims submission methods. This process is occurring in phases.

2) How much notice will MAA give Providers/Submitters before Dual Support is discontinued?

It is customary to give at *least* 30 days notice.

3) I'm not going to be ready. What should I do?

Please contact us as soon as possible to discuss the barrier for your business. As long as providers and payers are making good faith efforts and are close to compliance, no one should be penalized. In fact, the law was never intended to punish providers but to make life easier for them in the long run. HIPAA compliance is something that will benefit your office, so you should be working on it. However, it also is a mandate in federal law, so the grace period will not last forever.

4) Can I continue to submit paper as I currently do now?

Yes. However, it is important to keep in mind that paper claims take much long to get processed. You can reduce the payment wait time for your claims by 50 % when billing in the HIPAA compliant electronic format.

5) What if I just revert to paper claims? I heard you don't have to be compliant to file paper claims.

DON'T DO IT! Paper claims will dramatically slow down claims processing. It would take an enormous increase in our staffing to process any significant increase in paper claims. Our dual support will allow providers to file under their

old filing systems, so there should be no need to file paper claims. But the biggest argument against it for providers is that a big increase in paper claims will simply slow everything down, including your payments.

6) Are Washington providers currently submitting through a Web site? If so, what do they need to complete to continue that?

YES – ECS (Electronic Claims Submission) is a Web claims-filing application developed by DSHS nearly two years ago to let providers switch from paper to the Internet. Providers using ECS now can replace it with free software called WINASAP2003 that is available on our Web site. The WINASAP2003 software is HIPAA compliant. Another option for HIPAA compliant electronic claims submission is the WAMEDWeb application that is also available at

7) What is the process for discontinuing service to Medicaid?

Contact the Provider Enrollment line at 1-866-545-0544 Manager.

8) Do Washington State providers HAVE to bill electronically?

NOT YET – Currently, there is no state mandate to submit electronically, but similar rules have passed in a number of other states and there is talk in the Legislature about requiring electronic billing because it would save money for both providers and the state.

9) Where can I find a copy of the companion guides?

Companion guides for the different transactions are posted on the Web site of ACS, MAA's HIPAA vendor. The URL is: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm

MEDICAID BILLING INSTRUCTIONS

10) Where can I find a copy of the billing instructions?

Billing instructions are posted on the MAA Web site's Provider Publications section: http://maa.dshs.wa.gov/Download/PublicationsFees.htm

11) I currently bill Home Health claims electronically on the HCFA 1500 MACNet format. With HIPAA, will these claim types be considered HCFA1500 or UB92 transactions?

These will be the same during dual support. Please check the Billing Instructions for code changes.

12) Are treatment plans required before Home Health claims can be sent for processing?

Treatment plans are a requirement. Please refer to Page E1 of the Home Health Care Billing Instructions

13) What changes do I have to make to my current electronic billing system to become HIPAA Compliant?

Please refer to the implementation guides for information. You are required to have ANSI x12 HIPAA Compliant Claims.

14) Who do I call with a billing question?

Call the MAA Provider Inquiry line at 1-800-562-6188.

15) Does Washington State have Field Representatives who can visit us on site?

Yes, although these happen infrequently because of staffing. To request a field visit, call the Field Representative Manager 360-725-1020.

16) Will we continue to get our Remittance Advice (RA) by mail?

YES. However, you are also able to receive them electronically. You will need to enroll with our vendor ACS EDI Gateway, Inc. to use the WAMedWeb application and also have software that will translate the 835 Transaction (Electronic RA). MAA is recommending that you execute your own search to determine which translation software product best suits your business needs.

IMPLEMENTATION GUIDE

17) What is the 837P Claim Frequency Type Code? What do I put in this field?

The 837 P (professional) is listed in the Implementation Guides on page 173.

18) Where do I put my Performing Provider Number?

Please refer to 837P on page 297 of the Implementation Guides. Please reference – 02.

19) What is my Taxonomy Code and where do I put it?

It is not a required field until the National Provider Identifier (NPI) is in place. The final NPI rule is anticipated late in December 2003. There is a 2-year implementation date after the final rule has been released.

20) Will the Medicaid system begin accepting a value of "Medicaid" in the Group Name Field (Subscriber Information Loop 2000B:SBR4) of the 837I file?

It will not be necessary to populate a value of "Medicaid" in the situational SBR04 segment of the 2000B subscriber information loop of the 837I. Any information sent to report or advise of "other insurance" (any insurance in addition to Medicaid for the subscriber) will be read from the 2330B Other Payer Loop(s).

21) When billing for injectable drugs dispensed by the provider's office, where would we report the NDC code corresponding to the HCPCS or CPT code?

The CPT or HCPCS would be reported in Loop 2400 Professional Service Data Segment SV101-1 and SV102-2 with the corresponding 11-digit NDC in the Drug identification Loop 2410, LIN02 and LIN03.

22) Can you tell me the PIC (Patient Identification Code) format for DHSH Medicaid?

Loop 2010BA, Data Segment NM109 Subscriber Name.

For Medicaid purposes the subscriber is equal to the patient. The format for the Medicaid recipient ID is 14 characters. First initial, Middle Initial, *(if no middle initial use a dash)*, birth date as MMDDYY, first five letters of last name *(if last name less than five letters, space fill; if last name is a hyphenated last name the hyphen is included as one of the five characters, if last name includes an apostrophe, the apostrophe is included as one of the five characters;* with a tiebreaker (either alpha or numeric) as the final character. EXAMPLES:

- JD010301DOE A - Last name less than five characters
- N-020310CLINEA - No middle initial
- DL020301RUS-KA - Hyphenated last name
- NN020310O'LEA2 - Apostrophe last name
- AB010203EMANS1 - Numeric tiebreaker

Loop 2300 NTE - Claim Note This field can be used at the provider's discretion. To facilitate the successful outcome of your claim, we will be reading this field for information required in various billing instructions and/or where state regulations mandate information that is not reported elsewhere within the claim data set.

Please refer to your billing instructions and memorandums.

An example would be the “I” indicator for Involuntary Treatment Act (ITA).

PROVIDER NUMBERS & ENROLLMENT

23) Does the provider need to enroll all their performing providers with ACS EDI Gateway?

It depends on the billing process for your business. Not all providers must be enrolled in order for your business to send claims. The Office Administrator for your business can add or modify the submitter numbers that your organization bills for by using the My Account options on the WAMEDWeb menu bar.

24) What is the MMIS number?

The MMIS Number is the provider’s Medicaid number. It is the way MAA identifies providers in the system.

25)How many digits are the provider numbers?

The provider number is seven digits long.

26) Where can I look up a provider’s Medicaid Provider Number

Medicaid Provider Numbers on the following MAA web site:

Provider numbers are also listed on the Remittance Advice (RA) sheet to the right of the notation “Provider Number.” Providers receive confirmation of this number when the sign up with Medicaid.

27) The Submitter’s packet that I downloaded from ACS EDI Gateway lists three different places for numbers. What are these numbers used for?

The provider numbers are the numbers of the individual providers in your office.

The group number is the number that you bill under – typically, several providers in the same clinic or group use only one provider number for billing.

The Trading Partner Identification Number (also known as the submitter number) is issued to you when you have completed enrolment with ACS EDI Gateway. This number is used by ACS EDI Gateway to identify you in their system an dis also used for identification verification.

TESTING

28) How do I create test claims? How can I get started? How many test claims should I send?

The first thing you must do is get enrolled and get a submitter number for testing. Then you should call our vendor, ACS. The ACS testing call center number is: 1-850-558-1630.

29) I've downloaded WINASAP2003 and created the necessary tables. What do I do next?

You should create a test file, just as if you were preparing a real claim, and then send it to ACS EDI. If you need assistance downloading the software, you may call the ACS EDI Support Unit at 1-800-833-2051.

30) What is EDIFECS?

EDIFECS is a commercial software package that tests HIPAA transactions for format and structure. It is available to providers on the Internet. We want all Medicaid submitters use it first to make sure their claims are correctly formatted. To get set up for EDIFECS testing, call ACS at 1-850-558-1630.

31) Who do I talk to about testing with EDIFECS?

You should call the ACS testing help desk at: 1-850-558-1630.

32) How do I know that my test claim worked in EDIFECS?

The EDIFECS application provides detailed responses immediately after processing your file to explain whether the claim encountered problems or was handled correctly. (1-850-558-1630.)

33) Can MAA provide me with a list of Billing services, intermediaries, clearinghouses, and software vendors that are HIPAA Compliant and MAA Approved?

This information is posted on the ACS web site at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm

34) What if my clearinghouse told me not to worry about testing, that it would just take care of everything for me?

Medicaid encourages all providers to test. In other states, clearinghouses that failed to test their providers' live claims sometimes encountered major problems when they reached that stage. We suggest you ask your clearinghouse to send a batch of YOUR test claims to make sure they work.

35) What is the next step of testing after EDIFECS?

EDIFECS checks the format of the claim. After EDIFECS, providers and submitters need to find out whether the content of the claim is correct. At the second level of testing, test claims will actually be sent into the translator, or "middleware," at the front of the MMIS system. Good claims will pass through the translator into MMIS for adjudication. Remittance advices from these test claims will be sent to you for your review of how they processed. Flawed claims will be tripped up and won't go all the way. Feedback on how your claims did is available at the ACS helpdesk. (1-850-558-1630.)

36) How will I know whether my test claim worked in the Middleware and was passed on to MMIS?

Once the test claims are inside either the middleware or MMIS, operators of the system will be able to identify the claims and determine the problem. Feedback on how your claims did is available at the ACS helpdesk. (1-850-558-1630.)

37) I submitted a batch a batch of claims, and I haven't received a 997 Functional Acknowledgment (positive or negative).

You should allow at least one business day for the 997 reply to your batch of claims. If you submit claims on a weekend or holiday, allow one extra business day. If you haven't received a 997 within the specified timeframe, it's possible that the file containing the batch of claims was rejected at the ACS EDI Gateway. If this is the case, often the problem causing the rejection can be resolved by the EDI Call Center, and your file can be processed as normal. See the FAQ on "Rejected Files" to learn the causes for file rejection

38) What can cause a batch of HIPAA Compliant transactions to be rejected at the EDI Gateway?

There are a number of conditions that will result in file rejection on the EDI Gateway:

- You've submitted a file marked as "Test" in the ISA segment on the production WaMedWeb portal. Resubmit the file on the correct portal, or correct the transaction header to indicate the proper mode

- You've submitted a file marked as "Production" on the test WaMedWeb portal. Resubmit the file on the correct portal, or correct the transaction header to indicate the proper mode

- ISA Sender and Receiver ID in the transaction header do not match the submitter profile associated with your logon ID. Correct the transaction header, or logon to the proper account for this file of transactions.

- The transaction type in your file is not activated in your submitter profile. Correct the transaction type in the file, or work with ACS EDI Call Center to activate the appropriate transaction type.

Note - in some cases, a reject file will be accompanied by an error message on your screen. In other cases, there may be no immediate indication the file was rejected, but rather will be indicated by the absence of a 997 in the appropriate time frame (see previous FAQ)

39) What do I do if my claim failed? Should I resubmit it?

Flawed claims should be repaired and resubmitted until the submitter is notified that the claim was adjudicated properly. (1-850-558-1630.)

40) How will I know if my claim was accepted or rejected by MMIS?

Once a claim is inside MMIS, operators will be able to identify the flawed claims and determine what problems led to the stop.

41) How will I know what was wrong with my claim?

A remittance advice will be sent to you that will contain the result of the claim, whether it paid or denied and the reason for denial.

42) Will I receive a copy of outcome of the adjudication so I can see whether my claim was paid?

Yes, a Remittance Advice for the test claims will be sent to the provider.

43) I'm in production, but I received a Test Remittance Advice report for one of my batches - why?

The possible reasons are:

- The claims were submitted in a batch that was marked as Test. In addition, if the claims were submitted using the web portal, they were submitted on the Test Web Portal rather than the Production Web Portal (Test batches submitted on the Production Web Portal are rejected immediately).

- The claims were submitted in a batch that was marked as Production, but the pay to provider associated with the claims is in Test status in the Medicaid system. This can happen if the pay to provider was not included in your list of providers when you notified Medicaid that you were ready to convert to production. If this is the case, you can correct the situation by notifying Medicaid via http://maa.dshs.wa.gov/dshshipaa/prov_survey.htm and indicating the provider number.

In either case, if the claims should have been processed as production claims, you'll need to correct the problem and re-submit the batch.

44) I submitted a batch of production claims, and I received a 997 Functional Acknowledgement, but none of the claims in that batch appeared on my Remittance Advice and Status Report - why?

The possible reasons are:

- You submitted the batch too late to make the weekly payment cycle. Currently, this is about 12:00 noon Pacific Time on Tuesday. In this case, the claims will appear on the next weekly payment cycle.

- You received a 997 Functional Acknowledgement, but it was negative rather than positive. In this case, you should correct the problem indicated by the 997 Functional Acknowledgement and re-submit the batch.

- The claims in the batch needed manual intervention to allow them to be processed. Occasionally, some characteristic of the file, the claims in the file, or your trading partner profile on the ACS EDI Gateway will cause a file of claims to be delayed. This can cause a file that would have otherwise made the weekly processing cycle to be delayed until the next weekly cycle. In this case, , the claims will appear on the next weekly payment cycle. Occasionally, there is a condition that prevents further processing of the file. In this case, an ACS EDI Business Analyst will contact you to will explain the problem and the action you need to take to remedy the problem.

WAMEDWeb (WEB PORTAL)

45) What is the web portal?

The Web Portal refers to an application that will eventually handle all the HIPAA transactions. On October 16, providers will be able to register and log on to the Web site and conduct real-time eligibility inquiries, receive real-time eligibility responses, retrieve reports such as error reports, health plan enrollment reports, etc. Eventually, providers can enter the Web portal and use it to submit claims.

46) I am having trouble logging on to the Web Portal.

Call our EDI vendor, ACS, at the EDI Call Center: 1-800-833-2051.

47) I'm able to log on but still having trouble.

Call ACS: 1-800-833-2051.

48) How secure is the WAMEDWEB?

WAMEDWEB uses 128-bit encryption for all Transactions. 128-bit encryption is an exceptionally safe form of security. This is the same kind of encryption used for e-commerce (i.e. online banking).

49) Why does the WAMEDWEB require me to change my password so often?

WAMEDWEB requires a password change every 30 days. The schedule for password change helps to ensure a higher level of security.

50) Can Medicare claims be created interactively via WAMEDWEB?

No, the WAMEDWeb application is intended for Medicaid claims only. The 837 interactive functions for Medicaid claims submission will be available later this year.

51) Can I use the 270/271 in place of an Award Letter for billing

No, the 271 do not contain the same information as an Award Letter. Award Letters contain Spend down information that is not provided on the 271 Response.

52) How often does the patient eligibility information get updated?

Patient eligibility information is updated on a daily basis.

53) Can the 271 Response be used in place of a Medicaid Coupon?

Yes, if the 271 Response provides the correct eligibility information for the client being seen.

54) How far back can you look up eligibility information using the 270/271 transaction?

Eligibility information goes back 1 year.

55) Does the 271 Response contain Spend down information?

No. Spend down information is listed on the award letter.

56) Where is the Match Code shown on the 271 Response?

Matched Codes are not included in the X12N format requirement.

57) Does the 271 Response contain Take Charge Program information?

Yes, this information will be included on the 271 Response if the patient is covered.

58) Does the 271 Response contain the Primary Care Physician information?

Not at this time, however DSHS may include this information in the future.

59) What does "Manage Proxies" mean via WAMEDWeb?

Manage Proxies provides the invited user the ability to accept the invitation to join an organization or decline it. If it is declined, the Office Administrator who sent the invitation will receive an email of the choice to decline.

60) Where are the 824 Transactions displayed?

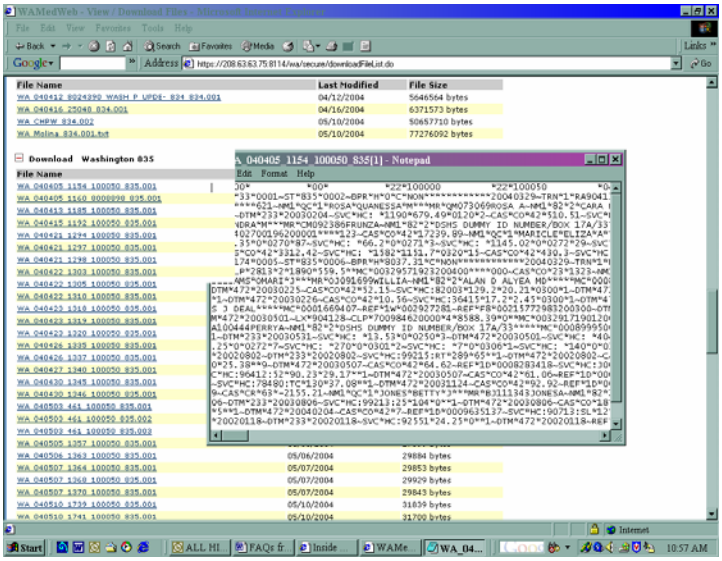
The 824 Transaction is displayed on the view/download menu option.

61) Where can I find software to translate the 835 Transactions?

DSHS recommends that you conduct your own research to find software that will allow you to do download and translate the 835 Transaction into a readable format.

62) Why do I need a to translate the 835 Transaction? The un-translated 835 Transaction format can be difficult to read. What does it look like?

Example: Opened un-translated 835 Transaction



63) How far back can I look up information for the 835 Transaction?

You cannot go back in history to retrieve 835 Transactions. The current 835 Transaction information is only available for 60 days. You can choose to continue to receive paper Remittance Advices. All reports displayed on the View/Download Menu of the WAMEDWeb application are available for 60 days follow their original production your system.

WINASAP 2003

64) I've downloaded WINASAP2003. What do I do next?

You should create a test file, just as if you were preparing a real claim, and then send it to ACS EDI. If you need assistance downloading the software, you may call the ACS EDI Support Unit at 1-800-833-2051.

65) Where do I put the EPA number?

The 837D Prior Authorization/Referred number can go at the line or header. If procedure needs EPA put on line.

66) Why shouldn't I check the Encounter Claims box on the Claims Data Screen?

Please do NOT check this box this will deny your claim for production status and you will have to re-submit your claim.

67) Will WinASAP2003 recognize all three of my submitter numbers

WinASAP2003 will only recognize two submitter numbers. Submitter Numbers can be input in the Primary Identification and Secondary Identification fields when setting up your Trading Partner information.

68) When creating a 837P claim, should I skip the Diagnosis Code fields because they are not underlined?

No. Please complete this field. Even though this field is not underlined in the WINASAP2003 application, Medicaid requires it for claim processing.

69) Why does WinASAP2003 allow me to submit claims when I select "No Provider is Not Allowed to Release Data" as an answer in the Release of Information Code field? Isn't this a violation of the HIPAA Privacy Rule?

WinASAP2003 will allow you to transmit claim information as long as you have all the required fields completed when creating a claim. Your Trading Partner Agreement language authorizes your electronic claims submission in the compliant format, but does not authorize other non-compliant methods of communication of PHI.

70) What does Mutually Defined mean?

Mutually Defined stands for a jurisdictionally defined procedure and supply codes used for Workers Compensation claims (not used by DSHS).

71) Will the Place of Service for Dental claims be expanded to offer more selections?

No, the selection currently offered in the "Place of Service" field for Dental claims is built based on the HIPAA Implementation Guide.

72) Please define HIEC under the "Service Qual" field when creating a Professional claim?

a. HIEC stands for Home Infusion EDI Coalition (not used by DSHS).